Analytical Framework for the Resolution of Conflicts and Crises in the Israeli Health System

Adi Niv-Yagoda[*]

Abstract

The Israeli health system consists of approximately 200,000 employees in a variety of positions, such as: doctors, nurses, pharmacists, psychologies, physical therapists, lab workers, speech therapists, occupational therapists, dieticians, orderlies, administrators and housekeeping workers and many more. (Ministry of Health, 2016). The system has gone through long-lasting struggles, conflicts and crises initiated by power groups and various functional representations and unions. This article will focus on conflicts occurring between doctors, in their professional occupation, and the governmental ministries (Health and Treasury). In addition, it will examine the processes that encourage the occurrence of conflicts in the health system. Even though doctors do not represent the entire health system, it is important to emphasize that they are its beating heart. Their weight in the general health system is extremely high, much higher than their relative part therein.

In addition, this article will examine a struggle by doctors to shorten their long shift hours, by exposing the root causes and the reasons that led to the struggle's demise, without the achievement of their declared goals. This article will suggest that tools appropriate for a true resolution of conflicts in the health system should be tailored and specific to the complexity of the system (as in a delicate surgery), as opposed to more general tools such as mediation, and certain "copy-paste" tools used for conflict resolution in other disciplines.

Keywords: labor disputes, health policy, public health, conflict resolution.

1 Preface

Crises and conflicts are common in the Israeli health system. In fact, since the 1970s, the Israeli health system has faced a continuum of significant crises and conflicts. Crises originating in ongoing budget cuts, limited resources, working conditions, professional interests and a variety of personal and group motivations (The German Committee, 2014; Rabin et al., 2010; Mironi 2011). Crises and conflicts that throughout the years shaped and scarred the health system, and affected the various stake holders participating in them.

* Dr. Adi Niv-Yagoda, Ph.D, LL.M, LL.B is an expert in medical law and health policy; Advocate and Lecturer at the School of Medicine and Faculty of Law, Tel Aviv University.

doi: 10.5553/IJCER/221199652017005001004

It is important to highlight the fact that conflicts and crises in the health system tend to have their own, singular characteristics. The health system is subject to constructional principles, budgets, and frameworks of professional, legal, and ethical rulings. In addition, to comprehend how to resolve current and future issues it is imperative to become acquainted with past disputes, as well as the history of each of the stake holders in the health system, the complex interrelationships, evident and obscure between them, and the infrastructure upon which conflicts and crises develop. De facto, crises and conflicts that were allegedly resolved – continue to percolate, subterraneously, till the next, inevitable, outbreak. In a system instilled with interests, the resolution of one conflict may result in the onset of a new one. Struggles appear to get settled with budget additions, however, careful inspection will indicate that in fact the resolution is the result of a zero sum game, and an achievement of temporary peace, for limited time only.

2 The characteristics of the Israeli health system and the way in which they affect conflict

The point of departure for the discussion is that the way to find an effective and good solution must pass through recognition and understanding of basic problems in the Israeli health system. This includes the realization that behind most of the professional conflicts that have taken place in recent decades, there were interests alongside economic incentives. In contrast, professional conflicts have been translated mainly into financial discussions, and have often been resolved after mutual power games and hand-downs between government ministries and representative organizations. Such behavior did not provide a proper and genuine response to the fundamental problems that led to the conflict, thus keeping in place the conditions for the promotion and empowerment of the next conflict. In practice, rather than channeling the discourse towards broad solutions in the health system, the discourse focused on specific financial solutions. Thus, over the years, opportunities have been squandered to grow out of the existing conflict, and to build long-term mechanisms for improving the quality of medicine, working conditions and conflict management.

Based on the above, the methodology of the discussion in this article seeks to present and discuss the conflicts of physicians that take place in the Israeli health system using the conceptual framework proposed by Smith and Martinez in their article 'An Analytic Framework for Dispute System Design' (Smith & Martinez, 2009). This is done by focusing on the following points: (**A**) the economic incentive and its impact on creating or preventing the conflict; (**B**) identifying stakeholders, their relative power and how their interests are represented in the health care system; (**C**) Recognition and analysis of previous conflict situations.

2.1 The effect of the economic stimulus – the increase in private budgeting and its influence on the profession's homogeneity

Medical doctors are the beating heart in the body of the health system. They are the most wanted and sought after manpower resource in the health system.

Almost all institutional players, in both the private and public sector, pursue this resource. Hence, a reality of inelastic demand, along with doctors' scarcity, creates significant leverage for this profession, in struggles for bettering work conditions and salaries – against the private and public health systems. Simultaneously, an ongoing policy of budget cuts and "starvation" has created and fortified dependence of the public health service providers on the private medical system, and addiction to it, through the complementary health insurance. Health Insurance policies have become increasingly prevalent and significant, while being a contributing factor in the rise of the private health expenditures (Ben-Nun, Ahdut, 2011). De facto, the decrease in the relative part of the public finance and the constant increase in the private finance (OECD health statistics, 2018), has led to a more accessible private health system, which is more attractive to both the patients and the doctors. Thus, with unprecedented growth in the medical insurance market in general, and the complementary insurance in particular, the private dimension WITHIN the public health system has increased and grown significantly. (Ben Nun, 2009). In effect, these developments have encouraged the privatization and commercialization of the health system in Israel (Filc, 2007; Svirsky, 2007). The private health system has lured doctors into its embrace with substantial financial temptations. Yet higher income potential in the private health system has posed a challenge to the entire health system. In the presence of growing temptations and the evident increase in medical doctors' earnings, an internal pressure to increase wages has emerged in the public health sector as well. This pressure is both ostensible and subterranean, and despite the regulator's efforts to control the inflation in doctors' wages, has created an occasional conflict or crisis. Note, that for the most part, the governmental policy that allowed a constant increase in private financing along a decrease in public financing, and privatization processes in the health system – essentially narrowed the ability of the Ministries of Health and Treasury to lead a responsible and balanced wage policy in the public health system. However, alongside the negative influence of the progression of the private dimension on the power of the regulator, the new reality challenged the Israeli Medical Association – the Histadrut (IMA). The privatization and commercialization processes generated the "disarmament" of the centralized power of the IMA. Economic interests and factors enhanced the prior subtle differences within the profession, and slowly threatened to defuse the homogeneous, centralized IMA as the sole representative of all medical doctors in Israel.

2.2 The representative organization as an interested party – professional analysis

The Israeli Medical Association (IMA) is the organization authorized to sign, in the name of all medical doctors, general collective agreements with the state. However, inter-professional processes have led to a constant erosion in the powerful status of this organization. The impact of this erosion has crossed profession borders and dictated new rules to the entire health system. While in the past the IMA represented the lion's share of the medical doctors in Israel, both in hospitals and in the community, and in all professional phases – interns, residents and fellows (Mironi, 2011), over time the medical profession went through a pro-

cess of organizational and political devaluation. This analysis was influenced, among other things, by the dual position of the IMA, as well as by the internal and external dialect regarding the integration of the private medicine alongside public medicine (Davidovich & Rosine, 2009). On one hand, the IMH acted in public, judicial and political venues to strengthen the publicly financed medicine, and in some cases explicitly opposed the privatization of the health system. On the other, the IMH acted to reinforce the private hues within the health system, including explicit support in implementing Private Medical Services (PMS) in all public hospitals in Israel, reinforcing complementary health insurance (Avni, 2017). Its dual position ended up enhancing the different interests of various groups within the medical doctor profession (see details below).

It seems that the main tipping point occurred after the doctors' struggle in 2000. By the end of the struggle, internal disapproval was expressed regarding the achieved agreements, and created the first cracks in and homogenous public face of the profession. The cracks deepened in 2011, till they became internal – but public – power struggles, and caused doctors to split into subdivisions of representation. Gradually, sub-groups with professional distinctions (e.g. interns, state doctors) began claiming autonomy, asserting that the IMH did not represent their specific interests, and in some cases, so they claimed, was even working against them. In this process, groups of doctors with distinctive characteristics were created and demanded recognition and autonomy, through which their subprofession would be best represented. As aforementioned, in the past the profession used to speak in one voice, while today it is represented by many voices and faces. Back to our topic – it should be emphasized that the internal rupture in doctors' representation groups impacted the ability to prevent, manage or resolve conflicts in the health system. Inter-professional interests complicate conflicts, or more so – inter-professional struggles may, in some cases in themselves accelerate to a major conflict with wide-ranging impacts.

2.3 A history of conflicts and crises and stake holder experience – know the past for the future

In order to avoid and/or resolve future crises, it is required to become acquainted with past disputes, as well as the interests, including the claims and the solutions that led to conflict resolution. The history of crises and shutdowns in the health system indicates that at the basis of most conflicts that developed into significant crises was almost always the will and motivation of a professional body to improve working conditions, mainly the wage component of the group members. Note, the constant will for the improvement of working conditions and wage is not specific to Israel, and stand at the heart of crises in health systems worldwide (Tanne, 2008; Kornacki & Silversin, 2002). This central interest is at the heart of the gap between the claims for which the crisis was declared (along with the rhetoric that accompanies the conflict) and the accomplishments that bring the crisis to an end.

The doctors' strike in 1976 is the opening point to examine the structure and nature of organized struggles and significant crises that occurred in the last decades in the health system. During that strike, doctors cancelled all planned surger-

ies (except urgent surgeries), patients were left hospitalized without release notes, hospital clinics were shut down and doctors handed in their resignations. After 58 days of striking, the crisis ended and doctors went back to their posts with the following achievements: a salary raise of 2.5%, constant wage updates, compensation per seniority levels, update of compensation for shifts and on call duty, shifts were limited and more (IMH website). Seven years later, another labor dispute was announced, and in 1983, a new, lengthy strike had started (117 days) during which some doctors abandoned hospitals, resigned and even went on hunger strikes. This strike opened with many different claims, among them claims to improve working conditions, wages, and finding solutions for patient distress within hospitalization systems. However, the resolution of the crisis and the ending of the strike were achieved only after all sides agreed on wage improvements (a payment mechanism for additional working hours, additional payments for hospital doctors, adapting new wage grades and a 10% payment addition for interns).

Later, in 1994, threats to shut down Clalit health system (hospitals and clinics) – and an actual one-day shut down – led to an agreement to increase payment additions to doctors, including consultation payments, a specific payment addition to doctors in internal medicine wards, additions per productivity, addition for promotion levels, addition of promotion paths and more. In 2000, and after the expiration of a working agreement signed six years prior, a crisis broke – this time it was one of the harshest, lengthiest crisis experienced by the Israeli health system. The strike opened on March 3, 2000, with a letter that was sent to all doctors saying: *"Dear doctors, the Ministry of Treasury hired an advertising agency to open a struggle against us. As those working at saving human lives, it is hard for us to declare a strike. During the months of negotiations, we were patient and restrained. In the offices of the ministry we were tackled with a wall of condescendence and social callousness. The appointed head of wages in the ministry, Mr. Rachlevsky said: "You will not get money. The only way open to you is to strike." By saying this he wanted to clarify that only by causing continuous suffering to patients, he will be willing to listen to us. For the tax payers' information: The Ministry of Treasury hired the leading (and pricey) advertising agency: Kesher Barel. In an intermal memo that came to our hands the ad men explain how they intend to fight the doctors: "We will attempt to divide them and alienate the interns from the residents." We are facing a tough struggle, but we are not afraid. We will remain unified and fight for what we deserve, until we win. As part of the organizational actions, we will do our best to refrain from imposing suffering on the patients"* (IMA website). As stated in this letter, and similar to past struggles, the heart of the struggle was the improvement of payment conditions. At last, at the end of 217 days of disruptions, sanctions, and general strikes, the parties agreed to seriously enter discussion that would lead to the resolution of this crisis. The discussion took a few weeks, at the end of which collective agreements were signed, including improvements in working conditions, including a 13.2% raise, changes in wage components that enabled wage increases, increase in pension coverage, and assigning a public committee to examine the public health system and the doctor's position (Amorai committee). In addition it was agreed that the doctors commit to not shutting down the health system for at

least ten more years (until July 13, 2010), and that any future dispute will be settled in an arbitration process. Needless to say, the signing of the agreement that brought to an end a lengthy and strenuous crisis, was the opening point for the next crisis: the struggle for saving the public medicine in Israel.

After 10-year limitation on strikes discussions started for a new collective agreement. Those failed when neither of the parties was willing to compromise, and each side overruled the other's claims. These dynamics led to the IMA director's statement in a press conference on February 21st, 2011: "We are struggling today to save the public health system. We will not cease until we achieve further steps for its improvement." (IMA website). The director added: "We hope that after long and tedious negotiations, we will achieve a thing that the patients will benefit from, but if the Treasury will not accept our demands – all means are acceptable, and we will not hesitate to use them. We are not talking about a minor correction, we are talking about saving the public health system." Following the press conference, the IMA published its list of demands, including: increased pay for doctors, more hospital beds, raises that would attract doctors to working in the periphery and in required professions, additional treatments under the coverage of complementary insurance in public hospitals and hospitals in the periphery, 50% raise on hourly rate, improvements to interns' conditions, increase in wage of the seventh hour of shift work, additions to tenth shift, weekly day of repose, increase for doctors who are parents, ride to shifts, pensions and more. According to the IMA, those additions would, directly and indirectly, save the public medicine.

In effect, once the IMA declared that all means were acceptable, the health system went through an additional, extended crisis. A negotiation on working conditions escalated quickly to an overall crisis that brought on a vast shutdown of health services in hospitals and clinics, and culminated in demonstrations, protests and hunger strikes. This time, perhaps as a strategic decision, the IMA declared the struggle to be one for the sake of patients and the public health system. The decision was aimed to gain the public support for the struggle, and as leverage against the governmental ministries. However, the longer the struggle lasted, public support dwindled. Cracks started showing even on the doctors' front. During the negotiations between the parties, some of the younger doctors claimed that the organization neglected to represent them properly. The cracks became a rupture in August 2011, when a breakthrough appeared to be achieved during the negotiations. This rupture among the doctors would become the next crisis – the intern struggle. At last, after an arduous negotiation process, on August 25th 2011, an agreement was signed that brought to an end a five-month crisis. The agreement included, among other settlements – significant raises (preferring doctors posted in the periphery), one thousand additional doctor tenure posts, bonuses and more. According to the IMA, the signed agreement reflected an essential change of approach, in which – "Doctors who work more – gain more. Those who will invest themselves in public medicine will have significantly higher wages. Thus, we can ensure that the citizens of Israel will receive better and equal health services" (IMA website).

Nevertheless, and as said above, more often than not, the resolution of one crisis marks the inception of another. In effect, even before the struggle to "save the public health system" concluded, other conflicts had already started developing (Weisberg, 2011). Inter-professional conflicts worsened following leaks of the agreement's preliminary versions that were drafted between the IMA and various groups of doctors. Some considered the drafted agreements as insufficient and as non-representative to all doctor sub-groups. On the premise of their strong dissatisfaction of the signed agreement, during September 2011, 812 interns submitted letters of resignation to their respective hospitals (Roni Linder-Ganz, 2011). The collective, organized resignation was declared by the regional labor court as "an illegal organizational act", therefore it was annulled. (General Collective Dispute 722-09-11). Despite their resignation being annulled, this act marks the onset of the interns' struggle for recognition and self-determination. This inter- professional crisis inflamed gradually, and would be the baseline of an additional, future crisis in the health system.

As described above, the internal professional cracks deepened from one crisis to the next, and led to division and ruptures within the guild. Thus more voices that claimed the IMA was not representative of them anymore were heard. For example, the head of "Hospital Doctors Association" (HDA) claimed, in September 2011, that – "the HDA is a part of the IMA, and if some doctors are considering resigning from the association – it will be against our declared policy as of today. We will gather people, and hopefully, in a democratic way – we will change the IMA from within, so doctors will be represented per their expertise, and not per their employer. I hope that we will gain significant influence in the IMA for the betterment of all hospital doctors' conditions" (Linder-Ganz, 2011). Another example of escalated internal disputes can be found in the power struggle between the "State Doctor Association" and the IMA. This struggle crossed the borders of an internal battle and became a public, organizational and legal struggle (Opening motion 56290-05-14). These struggles accelerated the professional depreciation of the representative organization.

However, unlike the Hospital Doctor Association and the State Doctor Association, both recognized sub-groups within the IMA, the independent organization of interns set a new goal – an autonomous representation for interns. This organization was founded in 2011 and culminated on April 27th 2015, when the nonprofit "MIRSHAM" was registered – "The Isreali Medical Intern Organization." It requested to be recognized as the sole organization representing the medical interns, justifying its existence by claiming that "throughout the years the medical interns have asked to be an active and collaborative part of the IMA, but when the results of the struggle were revealed in 2011, we had no choice but to organize separately, to address our group power, to act for our benefits and interests, and to make the state listen to our demands during routine as well as struggles (MIRSHAM website)." As mentioned, in the reality of inter-professional conflicts and dissatisfaction with the collective agreements signed in 2000 and 2011, the medical interns decided to start their own struggle to "shorten hospital shifts". I will use this struggle as a test case, by presenting the cause and reasons that left the medical interns deprived of the results they were aiming for.

2.4 The Medical Intern Struggle as a Test Case

Who would want to receive medical treatment, or yet – a surgery, by a doctor that had been working for 24 hours straight? During such long shifts, doctors become less vigilant, less focused and less agreeable with their patients. This claim is the premise on which a group of medical interns started their publicly financed (HeadStart) struggle to shorten shift hours. At its onset, their struggle was widely supported and received positive publicity, but the struggle slowly came to a demise until it ended without achieving its initial goal. This raises the question why – as opposed to prior doctor struggles – and despite media support and public encouragement, this particular struggle failed to achieve its declared goals. It seems that the answer is multivariate and includes: the identity and characteristics of the struggle parties, the dynamics of the conflict powers (both those impacting and being impacted by the conflict), the conflict being an inter-professional and inter-group (among the medical interns themselves) and an entirety of clashing and contradictory interests.

For several years there has been a subterranean struggle, imbued with interests and resentments between the young medical interns and the power groups of the medical profession. The power struggles of young medical interns over autonomy and appropriate representation burst in May 2016, with the demand to significantly shorten the shift hours (26 as of today). Note, that the shift duration was specified in the 2000 collective agreement, where it was stated that doctor shifts would start at 8am and end at the same time the following day. It was also agreed that at the end of the shift, a handover is required between the doctors, at 10am the following day – a straight 26-hour work day, de facto. In a way, the medical intern struggle was uplifting – by comparison to prior struggles, which were mainly motivated by wage increases – no matter how presented and disguised. Note, notwithstanding the true significance of appropriate wages as a motivation for the employee doctor, in reality, wage increases are far from being the sole parameter, or ever the main parameter – in the change needed to reinforce and empower the medical profession in the Israeli public health system. Other conditions and working environment improvements may have a greater impact on the doctor's wellbeing. These are more significant not only to the doctors, but to the patients as well. Budget increases that go directly to doctors, will not necessarily benefit the patients, whereas budget increases for the improvement of doctor working conditions, including shortening of shift duration – are an improvement that may significantly benefit the patient's condition, to the extent of improving lifesaving chances. Hence the initial general support for the medical interns' struggle to shorten shift duration. The public identified with their distress, and furthermore – considered this struggle a means for the improvement of medical treatment and safety within the entire health system. The public perceived the interns' struggle for shortening shift hours as a common benefit.

However, for many reasons and causes, the interns' struggle, which resonated strongly within the public at its onset, came to its demise without the interns' achieving their goal of shortening shift duration. Threats to the health system succeeded in the past to get all the parties to open a meaningful negotiation pro-

cess, aiming to resolve the conflicts and bring crises to their end, while gaining the doctors significant triumphs in their struggles. If so – what are the reasons impeding the success of the interns' struggle, resulting in their inability to leverage their power and negotiate with the government ministries?

- *Legal and Organizational Limitations.* In effect, and in view of their legal and organizational state, the struggle initiated by the medical interns was limited in its potential, impact and scope, so they couldn't create the required leverage on the administration. The legal limitations were previous collective agreements that bound the interns as well, and in fact prevented them from creating a significant, dramatic leverage.
- *Heterogeneity within the intern organization.* Another possible reason for their failure, is the diversity not only of the medical profession, but of the subgroup of medical interns, to the extent that some interns did not collaborate with the struggle, and some opposed it entirely, on the basis of professional disagreement with the goal of shortening shift hours. One should remember that as opposed to the professional group of medical doctors, that of the interns is volatile – their being tomorrow's residents and fellows. It is a transitional state where the interests are changing constantly with time, and along their professional career. An intern at the end of an internship is much less motivated to join the struggle. Another expression to their diversity is the inability to agree even on the struggle's declared goal. Interns in internal medicine, ERs, maternity and genecology wards supported the goal, while others (in neuro surgery, for instance) – opposed it. Thus, similar to autoimmune diseases, in many cases the diversity and lack of general support of a common goal and the ways to achieve it – harm the group's ability to run an effective, successful campaign. Furthermore, their professional group was not officially recognized – legally or organizationally. With these opening cards, the chances of the interns at the front of the struggle to actually create a crisis and achieve a negotiation process were very slim. More so – when the medical profession not only did not support and endorse their struggle, some would say – resented and impeded it.
- *Lack of Experience.* As opposed to the IMA's long experience in professional struggles, the inexperience of the medical interns was evident. Such struggle should be managed in multiple levels, against a large variety of direct (Ministries of Treasury and Health) and indirect (Clalit Health Service – the owner of the major part of hospitals, Ministry of Labor and Welfare, Ministry of Industry and Economy, Health nonprofits and organizations) parties. The interns' inexperience appeared in two main dimensions: 1) Customizing the struggle tools to the relevant parties 2) The ability to transform public support into a pressure leverage and achievements 3) Managing a disordered media strategy (e.g., frequent replacement of communication consultants harmed the management of an appropriate and accurate communication exposure). Hence it is important to emphasize that dosage, precision and timing are critical to the success of a struggle within the health system.

- *Modification of the Struggle Goals*. To a large degree, the point at which the public and media support of the medical interns' struggles started to subside, can be attributed to the protest tent that was constructed in Rabin Square, Tel Aviv. If up until then, the declared and central goal was the shortening of shift hours, other professional demands started to come up, in which the public and media had little or no interest. The demands shifted towards the need to establish an independent and representative organization for the medical interns. Hence, and in light of the development the struggle goals went through, and the fact that their activities continue to this very day, one has to wonder what was the real, authentic, distilled goal – for which the struggle began. That is – was it a restricted struggle for shortening shift hours (the declared goal) or was it actually an internal power struggle that would enable positioning the medical interns as a power sub-group in the health system (clandestine secondary goal)? And if both were at the baseline of the struggle, it could be that the main goal was actually the secondary and vice versa. It is known that the reality is more complex and less dichotomous, as shown in the questions above, and it is likely that both goals existed and merged as the struggle went by, a merger that eventually caused the interns who initiated the struggle to speak in multiple voices, in a way that did not fit the relevant target audiences.
- *Lack of stable financing*. Public struggles generally highly depend to a degree on available resources. This insight was clear to the protestors as the struggle continued, and made them think creatively of potential financing resources. Thus, intentionally and deliberately, the interns used the tool they considered most appropriate to a struggle, such as their own crowdfunding (via Headstart). The public did not remain indifferent and supported the struggle's declared goal. In less than 24 hours, funds exceeded the goal of 120,000 NIS. The resounding success encouraged the interns to increase the goal to 260,000 NIS (Linder Ganz, 2016). However, as in similar failing struggles, resources dwindled and fund sources wore out.
- *All or Nothing*. The "all or nothing" approach is very risky. The chances for the conflict to end unresolved are high – particularly when there is a significant and substantial gap between the sides. When one side is skilled, experienced, and with a strong ability to contain the situation (the government ministries) and the other ('MIRSHAM' - Medical Intern Organization) is an inexperienced novice, with no tools or leverage, internally divided and lacking the support of IMA its parent organization. Therefore, as part of planning future struggles, it is vital to be ready in advance with the compromise-range, and avoid gambling on the struggle with an "all or nothing" attitude. Past experience shows that many struggles and conflicts in the health system end up in compromises.

In light of all of the above, it seems that the struggle of the medical interns ended up with no resolution or achievements. But – as was also said before – the end of one struggle is often the starting point of a new one. True – the shift hours were not shortened as the interns demanded, but in effect – a movement was created

within the interns and hundreds of them joined MIRSHAM ("The Israeli Medical Intern Organization") – an organization that positions itself as the official representative of the Israeli medical interns.

In the near future, when the 2011 collective agreements expire, MIRSHAM will renew its struggle and initiate new courses of action – this time from a power position. Therefore, even though the official goal of the struggle was not achieved, it seems that a course was set to achieve the clandestine goal, which may have been the actual goal of the leaders of this struggle.

Now, and in light of the specific characteristics of the health system, I would like to present the challenges and tools that may assist the concerned parties or the mediators to resolve crises and conflicts in the health system.

3 Mediation as a concept for the resolution of crises and conflicts in the health system

Much has been said and written in Israel and the world in general, about the mediation process, in its various forms and styles. This process grew prevalent in the 1980s, and is a part of a broader approach that seeks alternative ways to resolve conflicts in the judiciary system (Alberstein, 2007). The literature reviewed developing models, from *essential mediation*, emphasizing proficiency and interest maximization, (Fisher & Ury, 1981) through *transformative mediation*, emphasizing the influence of the mediation process on the participants and the social dimensions (Bush & Folger, 1994) to a narrative-post-modern model emphasizing the participants' identities, including that of the mediator's (Winslade & Monk, 2000). However, the common denominator of all the mediation and arbitration models is that the process reflects the necessity of a colloquy between two (or more) sides, through a party external to the conflict. This party is conceived by the participants to be able to establish a baseline for a discussion that is reduce of the negative impacts the conflict has had on the involved parties to the possible minimum. Furthermore, this party will direct the participants to walk beyond the premise of the conflict and lead to a dialogue that may result in an agreement and a solution. More than once, as will be presented in this article, attempts to resolve crises and conflicts in the health system were described as "*mediation*", whereas the actual essence of the process was not aligned with the true and basic principles of mediation. One such example is the case of the oncology-hematology ward at Hadassah hospital (see discussion below), and in the Supreme Court's decision to enforce mediation process despite a vocal resistance to it by one of the conflict parties. The success of a mediation process depends heavily on the good will and consent of all parties prior to it. As said, "meditation" was initiated in the health system, whether or not it was compatible with the actual essence of the mediation models.

One of the mediator's main roles is to create the infrastructure of an honest and candid dialogue between the parties, by guiding and directing them to possible solutions. A mediator should lead a process of common, open and creative thinking between the parties, and raise interpretational suggestions, having in

mind the goal to break the conflict constraints and neutralize past resentments. The benefit of such process is the active part the parties take in trying to find agreeable and acceptable solutions. During the brainstorming for a solution, the mediator will encourage the parties to present as many options as possible – and cooperatively find the accepted resolution. This process contrasts with judicial proceedings or arbitration – where the parties are bound to accept a solution dictated by the judge or arbitrator.

By challenging the definitions of alternative dispute resolution (ADR) within the health system, one can find appropriate, potentially more effective methods (Smith & Martinez 2009). ADR includes a rich analytical framework of conflict resolution systems.

3.1 An alternative system for the prevention/ management of conflicts in the health system

Crises and conflicts in the health system are related to other developments that the health system has gone through during the past decades. Processes and trends expedited and impacted the creation of conflicts between the different parties to a high degree (Mironi, 2011). One should identify and recognize professional, political, economic and social processes, trends and inter-relations, in order to be able to prevent crises in the health system, or in order to cope with an existent current conflict efficiently and optimally. To this end, a useful analytical framework (DSD) should be constructed, through which it will be possible to understand and analyze conflicts within the Israeli health system, and will assist in putting together resolutions to conflicts via extra-judiciary tools (Smith & Martinez,2009). The analytical framework would focus not only on mediation, but also the prevention or management of conflicts in the health system. The system will first attempt to track the evolution of the health system, its functioning and its impacts. Further on, and based on historical learning of the system, one should examine what is the appropriate and suitable process to deal with the conflict. Finally, facing the conflict should be done by redesigning the health system in a way that, among other advantages, will be able to avert future conflicts.

3.2 Conflict Identification and Management

First, and as an opening point to deal with crisis situations, one should recognize that conflicts in the health system are legitimate situations of disagreement or rivalry that exist due to differences in professional or social points of view. They involve situations in which interests, positions, perceptions and values between the different parties collide, in relation to the current state of things, the appropriate state, and the professional ideal (Baron, 1990). Conflicts, when they exist in the realm of professional, honest and restricted discourse, can have their advantages, and may lead to process and result improvements in the health system. However, while the parties may attempt a professional and clean discourse, in reality conflicts seem to in foul personal relationships, undeclared interests (personal, professional or political in the larger sense) and an effort of a person or a group to mark territories. These conflicts have the potential to develop to local, system or nation-wide dimensions. At some point, one or more of the parties ini-

tiate tactical crises, and then the conflicts may get carried away to a chaotic condition. Conflicts have in common, at least in their first stages – uncertainty, lack of control and mutual faith, radicalization and polarization (Ross & Ward, A. 1996; Van Kleef & De Dreu, 2002). The "pure" professional discourse boundaries are violated, and the impact reaches beyond the scope of the direct conflict (for example: the disruption or shutdown of health services).

These situations usually have forewarnings indicating a possible development and deterioration from conflict to crisis. Premonitions should be identified before a professional conflict becomes a systematic crisis with vast affects. Similarly, the history of crises in the health system shows that one of the main reasons for deterioration is the lack of an accountable intermediary that will manage and direct the participant to a constructive and healthy dialogue. That is, many times local and insular conflicts in the health system develop to significant crises due to bad management or non-management. Hence, it is crucial to acknowledge that conflicts and crises should be managed professionally and wisely, and not allowed to take their own course. Absence of management increases the risk that a professional conflict will become a system crisis or that the crisis will deepen and worsen.

An insulated conflict might become a major crisis due to a lack of management, as illustrated in the incident of the pediatric oncology-hematology ward in Hadassah hospital, Jerusalem. This conflict started as a legitimate, professional, managerial disagreement between the ward manager and hospital management, but plummeted to a raging struggle between the parties. Until a very late stage in the struggle, the regulator chose not to intervene, and let the crisis resolve itself. Naturally, the conflict only intensified, to the very extreme point in which all the doctors in the staff – seniors and interns – resigned their posts, creating an eminent threat to the very existence of the ward, and thus bringing real harm (medical and emotional) to the young patients and their families.

One should stress that in such circumstances, the Ministry of Health should be obligated to take part in the crisis management, in order to control and contain the conflict. The Ministry of Health is in the position to lead and guide the parties, thus drawing the conflict boundaries and minimizing its impact on the entire public. However, in some situations, the Ministry of Health should act to involve, as part of the conflict management, a third party to divert the conflict into a constructive dialogue: a party that is able to lead and create a healthy, agreeable and effective discourse between all parties (Forsyth, 2006, 2010), while avoiding a judgmental position (Thompson & Nadler, 2000). The third party should be familiar with the health system and its different players, its singular characteristics and its varied interests. It should be able to identify all sides and stakeholders, direct and indirect, and be aware of the intricate relationships and correlations between them, including the existent limitations (professional, ethical, resource-related, etc.) and past resentments (Smith & Martinezi, 2009).

3.3 Educated and Responsible Management of Crises and Conflicts in the Health System

At times, only the formation of a crisis, or a deliberate creation of a crisis, will prompt sides to a lengthy and static conflict to start negotiating to advance their interests. There's a double challenge to managing a conflict and resolving it outside the judiciary system: 1) Bringing the sides to the negotiation table. 2) Having them conduct an honest and efficient dialogue.. It is necessary to emphasize that in this context, the "mediator" function is referred to in the larger sense of the mediation process. One must recognize the mediator as a party that is trusted to manage the crisis in an educated and responsible way, as part of an analytical framework of conflict and crisis resolution (DSD).

Owing to the particular characteristics of the Israeli health system, complex relationships have developed between the different parties. These relationships are delicately balanced on interests – when the common denominator, at least on the declarative level – is the "benefit of the patient". In many cases, the conflict is influenced by the sides' past experiences and experiments. Often, during a crisis and negotiation processes, the sides are dominated by extreme lack of mutual trust, lack of mutual appreciation, suspicion and similar emotions. It is therefore a preliminary challenge for the mediator, to create a common ground for constructive communication and trust building. Indirect communication between the sides, in the preliminary stage, may enable future meetings in which, assisted by the mediator, a trust building dialogue will take place. The mediator would be wise to channel this dialogue (and not just let happen) to neutralize egotistic considerations and redundant arm bending, and conduct a serious, direct dialogue. Note, often an honest consent of the conflict sides to convene and enter a negotiation process indicates a mutual willingness to resolve the status quo (those who benefit from the current situation will not easily agree to negotiate). It is important that the mediator tries to identify the hidden interest of the parties, as well as whether this is a futile negotiation process whose objective is to buy time and preserve the status quo, or whether there's a will to improve that starting point with additions and achievements.

A critical key point for resolving a crisis in the health system is set in the ability of the mediator, as a party that is trusted to wisely manage the situation, to identify, isolate, distill and map, as early in the stage as possible, the different motivations and interests that are at the heart of the conflict. It's important to understand whether this is a crisis originating in professional or ideological differences, or is it in fact a professional struggle to improve working conditions with the ultimate objective of maximizing defined interests. In addition, and as part of the dialogue created around a conflict or a crisis, each of the parties will attempt to construct and establish a narrative (serving its purpose), while trying to persuade that its narrative is the absolute truth, by attempting to delegitimize the other party's narrative. In effect, more than once, the conflict is actually a dialogue of narratives, and may worsen by it. The task of identifying, isolating, distilling and mapping – is particularly difficult in light of the fact that many crises in the health system combine and merge professional and ideological claims, narratives, reasoning and justifications (such as "saving the public health system", or

"for the benefit of the patients") and narrow professional interests (such as wage raises). An expression of a crisis that combines and merges claims and interests from both worlds (narrow professional interest and ideology) is the doctors' struggle in 2011 (see above). As said, the more a conflict develops to a complex crisis, characterized by multiplicity of sides, claims and interests – the higher is the challenge to the mediator. After the sides have consented to enter an honest and constructive negotiation process, the essential challenge to the mediator is to understand the real premise – hidden and apparent – of the conflict. The way to face this challenge is related to the mediator's ability to build a comprehensive and reliable 'conflict map'. Conflict map that would include that perceptive and analytical framework that examines the conditions and processes that are at the basis of the health system, with its different stakeholders. It is to be emphasized that the conflict map is actually a roadmap that will be a trustworthy starting point for the mediator to understand the true origins of the conflict. Conflict map that includes a dynamic and reliable database that will be used as an effective tool to finding a good, agreeable and long-term resolution for the conflict or crisis. For the conflict map to fulfill its role, it should be based on a wide range of information sources, and include the following:

1 Deep acquaintance with each of the players in the health system, with their particular characteristics;
2 Clear identification of the direct and indirect sides of the conflict;
3 Impacting and impacted sides of the conflict and possible outcomes (e.g. patient organizations, private health organizations, insurance companies, government ministries other than Treasury and Health and more);
4 Identification of the factors that impact the conduct of each of the sides in the conflict/ negotiation (e.g., knowledge gaps between the sides, suspicion, distrust, prior experience, risk aversion, resource limitation and more);
5 Identification of the motives for each of the sides (e.g., will to improve the status quo/maximize a certain interest, reliability of the information each side maintains and its interpretation, the ability to create committed, normative baselines, the perception of each side of the possible alternatives and more);
6 Identification of the narratives and the line that typifies the dialogue around the conflict/crisis;
7 Identification of the ostensible interests and uncovering of the hidden ones of each of the sides, direct and indirect, impacting and impacted.
8 Mapping of the interests and dividing them to four groups: common interests, contradicting interests, competing interests and particular interests;
9 Mapping hurdles (real and artificial) – professional, economic, regulative, ethical and social – inter-systematic and extra-systematic;
10 Preliminary assessment of the different options in light of available resources and probability.

I would like to emphasize that the conflict map is a working tool for the mediator, and not a document to be shared with the concerned parties – impacting and

impacted by the conflict, especially not with the actual sides of the conflict. The exposure to such document may impair the mediator's chances to lead the sides to agreements and a resolution. This is mentioned since each side being exposed to such information may choose to abuse it during negotiations, manipulate the information and data, harden its positions or exploit its power, in order to maximize its benefits and interests. Note that the validity and reliability of the conflict map depends on its being dynamic. That is – it is the mediator's professional duty to constantly update the information and data according to the development of the crisis and the advancement of the negotiation process. Up-to-date information may influence and redesign the negotiation process, as well as the resulting agreed solution.

4 Concluding Notes

The crises befalling the Israeli health system in the past three decades are a warning sign of the general and economic state of the public health system. They clearly indicate that the health system is going through constant grinding processes, and a severe lack of resources. However, a deep examination of the history of crises and conflicts, and the resolutions achieved thereafter, testifies that throughout the years, a strategy of seeking "industrial peace" has developed, without seeking true, in-depth resolution to essential issues. The central objective of this policy is to buy peace and time, by attempting to conceal the fact that the entire health system is suffering from severe budgetary erosion, privatization and commercialization. In fact, instead of gap-closing processes that create real solutions to essential problems, actions have been taken that create distortions in the health system. These actions encouraged the increase of private financing, gradual privatization and resource deficits in the health system. To a large degree it seems that in conflicts and crises – instead of dealing with the root causes of problems, the government ministries chose the "industrial peace" as an objective in itself, shutting their eyes to processes that severely harmed the public health system. This eye-shutting fed and nurtured the interests of power groups within the health system. This conduct also harmed the government ministries' ability to regulate and reinforce the public health system. As said, a situation that worsens as time goes by.

The crises occurring every few years in the health system are a warning sign to the erosion the system goes through. Since in fact every conflict or crisis is resolved by budgetary increases and raises, with new and additional collective agreements that buy "industrial peace", the next crises are inevitable. Since as long as the gaps between the private and public increase to the benefit of the private, and as long as the mechanism to resolve conflicts and crises is based on zero-sum games, the incentives and interests at the basis of those conflicts and crises will continue to exist in full force.

References

Alberstein, M. (2007). *Jurisprudence of Mediation*. Haifa: University of Haifa Press and Magnes (Hebrew).

Appeal of Civilians 399/15. The Association of Physicians for Civil Servants vs. the Israel Medical Association et al. (1.6.2016).

Association of Medical Specialists in Israel (www.mirsham.org.il).

Avni, S. (2017). *A Jewish man is allowed to cure: the development of discourse about the gaps in health in Israel*. Doctoral dissertation, Ben-Gurion University of the Negev (Hebrew).

Baron, R.A.(1990). Conflict in organizations. Psychology in Organizations: Integrating Science and Practice, pp. 197-216.

Belashar Y., Chairman of the Israel Medical Association, to the physicians (7.3.2000) (www.ima.org.il).

Ben Nun, G. (2009). From the National Health Insurance Law to the golden age and platinum. In: Doron, H. (ed.) *The health system - from the equal health insurance law to health inequality*. Jerusalem: Bialik Institute (Hebrew).

Bush, R. & Folger, J. (1994). *The promise of mediation: responding to conflict through empowerment and recognition*. San Francisco: Jossey-Bass.

Committee for Strengthening the Public Health System (German Committee) (2014). *Minority report* [Hebrew]. Jerusalem, Ministry of Health. (http://health.gov.il/Services/Committee/German/Pages/default.aspx, accessed 10 December 2015).

Edwards, N., Kornacki, M. & Silversin, J. (2002). Unhappy doctors: What are the causes and what can be done? *BMJ* 324:835-8.

Filc, D. (2007). The commodification of health care services: right or wrong?, *Mishpat VeAsakim*, 6: 102-123 (Hebrew).

Fisher, R. & Ury, W. (1981). Getting to yes: negotiating agreement without giving in. New York: Penguin.

Forsyth, D. R. (2006, 2010). Group Dynamics. Belmont, CA: Wadsworth.

Hopkins Tanne, J. (2008). US GPs are unhappy, underpaid, deluged by paperwork, and want to retire, study says. *BMJ* 337:a2711.

Israeli Medical Association, Physicians' Strikes in Israel, 1976-2000. (www.ima.org.il).

Israeli Medical Association, press conference, February 21, 2011 (www.ima.org.il).

Israeli Medical Association, Physicians' battle 2011-2012 (www.ima.org.il).

Linder-Ganz, R. (2016, May 24). Renewal of Residents' Protest: Raise 120,000 NIS a Day, *TheMarker*.

Linder-Ganz, R. (2011, August 4). Residents announce resignation: "worse than physical difficulty", *TheMarker*.

Linder-Ganz, R. (2011, September 11). Chairman of the Israel Medical Association (IMA): "There will be no beatings under the belt", *TheMarker*.

Linder-Ganz, R. (2011, September 20). 812 interns will resign in two weeks; department director: "afraid of disasters", *TheMarker*.

Ministry of Health, Jerusalem (2016). www.health.gov.il/Services/Pages/statistics.aspx.

Mironi, M. (2011). Experimenting with alternative dispute resolution as a means for peaceful resolution of interest labor disputes in public healthcare – a case study. *Law and Contemporary Problems* 74 (201): 201-224.

Opening motion 56290-05-14. The Association of Physicians and State Employees vs. the Israel Medical Association (3 December 2014).

Rabin, S., Maoz, B., Shorer, Y. & Matalon, A. (2010). *Rekindling the spirit: creativity, passion and the prevention of burnout in the medical profession.* Ramot, Tel Aviv University (Hebrew).

Ross, L. & Ward, A. (1996). *Naive realism* in *everyday life*: *Implications* for *social conflict* and *misunderstanding. Values and knowledge. The Jean Piaget symposium series, pp. 103-135*.

Rozin, A. & Davidovitch, N.(2009). The Israeli medical association in the 50s and 2000s. *Iyunim Bitkumat Isr.* 19, 56-92 (Hebrew).

Smith, S. & Martinez, J. (2009). An analytic framework for dispute system design, 14 *Harv. Negot. L. Rev*. 123, 166.

Swirski, B. (*2007*). Privatization of the public healthcare system in Israel: its manifestations and implications. *Tel Aviv*: *Adva Center* (Hebrew).

Thompson, L. & Nadler, J. (2000). *Judgmental biases* in *conflict resolution* and how to *overcome them. The handbook of conflict resolution: theory and practice*, pp. 213-235.

Van Kleef, G. A. & De Dreu, C. K. W. (2002). Social value orientation and impression formation: A test of two competing hypotheses about information search in negotiation. *International Journal of Conflict Management*, *13*(1), *59.*

Weissberg, H. (2011, August 30). The residents will protest against the agreement between the Ministry of Finance and the Israel Medical Association; Senior officials in the system will finance the residents, *TheMarker*.

Winslade, J. & Monk, G. (2000). *Narrative mediation: a new approach to conflict resolution*. San Francisco: Jossey-Bass.